

private contributions to fund the Wall of Remembrance.

S. 2009

At the request of Mr. WYDEN, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of S. 2009, a bill to prohibit the sale of arms to Bahrain.

S. 2042

At the request of Mrs. MURRAY, the name of the Senator from Hawaii (Mr. SCHATZ) was added as a cosponsor of S. 2042, a bill to amend the National Labor Relations Act to strengthen protections for employees wishing to advocate for improved wages, hours, or other terms or conditions of employment and to provide for stronger remedies for interference with these rights, and for other purposes.

S. 2089

At the request of Ms. CANTWELL, the name of the Senator from Rhode Island (Mr. WHITEHOUSE) was added as a cosponsor of S. 2089, a bill to provide for investment in clean energy, to empower and protect consumers, to modernize energy infrastructure, to cut pollution and waste, to invest in research and development, and for other purposes.

S. 2145

At the request of Mr. GRAHAM, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of S. 2145, a bill to make supplemental appropriations for fiscal year 2016.

S. 2148

At the request of Mr. WYDEN, the name of the Senator from Massachusetts (Mr. MARKEY) was added as a cosponsor of S. 2148, a bill to amend title XVIII of the Social Security Act to prevent an increase in the Medicare part B premium and deductible in 2016.

S. 2152

At the request of Mr. CORKER, the names of the Senator from Arkansas (Mr. BOOZMAN) and the Senator from Michigan (Mr. PETERS) were added as cosponsors of S. 2152, a bill to establish a comprehensive United States Government policy to encourage the efforts of countries in sub-Saharan Africa to develop an appropriate mix of power solutions, including renewable energy, for more broadly distributed electricity access in order to support poverty reduction, promote development outcomes, and drive economic growth, and for other purposes.

S. 2166

At the request of Mr. BLUNT, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 2166, a bill to amend part B of title IV of the Social Security Act to ensure that mental health screenings and assessments are provided to children and youth upon entry into foster care.

S. 2184

At the request of Mr. ISAKSON, his name was added as a cosponsor of S. 2184, a bill to direct the President to

establish guidelines for United States foreign development and economic assistance programs, and for other purposes.

AMENDMENT NO. 2621

At the request of Mr. WYDEN, the name of the Senator from Massachusetts (Ms. WARREN) was added as a cosponsor of amendment No. 2621 proposed to S. 754, an original bill to improve cybersecurity in the United States through enhanced sharing of information about cybersecurity threats, and for other purposes.

AMENDMENT NO. 2716

At the request of Mr. BURR, the names of the Senator from Wisconsin (Mr. JOHNSON), the Senator from Arizona (Mr. MCCAIN), the Senator from Delaware (Mr. CARPER), the Senator from Iowa (Mr. GRASSLEY) and the Senator from South Dakota (Mr. THUNE) were added as cosponsors of amendment No. 2716 proposed to S. 754, an original bill to improve cybersecurity in the United States through enhanced sharing of information about cybersecurity threats, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. BLUMENTHAL (for himself, Ms. BALDWIN, and Mr. MARKEY):

S. 2210. A bill to require the Secretary of Veterans Affairs to carry out a program to establish peer specialists in patient aligned care teams at medical centers of the Department of Veterans Affairs, and for other purposes; to the Committee on Veterans' Affairs.

Mr. BLUMENTHAL. Mr. President, in 2013, the VA estimated that about 1.5 million veterans required mental health services, which VA provides in a variety of settings. In addition to the traditional VA medical centers, veterans may access mental health services and support through Vet Centers—which often appeal to veterans because of their welcoming, home-like environment; Community Based Outpatient Clinics, which play an important role in telehealth delivery by connecting rural veterans to psychiatry services from the medical center home-base, a Veterans Crisis Line, VA staff on college and university campuses, and other outreach efforts. Another important means of delivering mental health services has been the inclusion of mental health professionals within primary care delivery through VA's Patient Aligned Care Teams, which improves the screening process and allows providers to recognize and treat mental health issues occurring among those veterans who present in their primary care locations.

In addition to providing ongoing care to veterans with mental health needs, VA plays a role in suicide risk assessment and prevention among veterans. According to VA, about one-quarter of the 18 to 22 veterans who die by suicide each day were receiving care through

VA. Suicide rates are even higher among those veterans who do not use VA for the health care services. Given the stigma and reluctance of some veterans to seek mental health treatment, veterans using VA for primary care may be missing a key entry point to the peer support model of care. Expanding this effective model into the primary care setting could provide another opportunity for veterans to access mental health services through VA. That is why, today, I am introducing—with my cosponsors Senators BALDWIN and MARKEY—the Veteran Partners' Efforts to Enhance Reintegration, Veteran PEER Act, a bill that would expand the peer support model of care for mental health services within the VA system to help ensure that veterans receive the effective and timely care they deserve.

VA has begun a program to co-locate mental health care providers within primary care settings in an effort to promote effective treatment of common mental health conditions in the primary care environment. This is a positive step; however, the peer support model of care for mental health services has not been similarly integrated. Research on the use of the peer support model of care for mental health services within the VA has shown that Peer Specialists helped patients become more active in treatment, which can promote recovery. Peer support was recognized by the Centers for Medicare and Medicaid Services as an evidence-based practice in 2007; and over 20 states have Medicaid reimbursement for peer support services. In response to the President's August 2014 Executive Orders to improve mental health services for veterans, VA committed to integrating and expanding the peer support model of care beyond traditional mental health settings into primary care clinics in order to better connect with veterans wherever they seek care. However, progress toward placing Peer Specialists in primary care teams has been slow.

The Veteran PEER bill would require VA to expand its use of Peer Specialists—VA employees who promote veterans' recovery by sharing their own recovery stories, providing encouragement, and teaching skills needed for successful recovery. These professionals may also provide case management assistance, help with accessing the right mental health care, and teach coping and self-advocacy skills. In general, peer support programs aim to develop veterans' self-management skills and restore participation in work and other social roles. Recognizing this effective model of care, this bill would require VA to establish Peer Specialists in Patient Aligned Care Teams within VA medical centers to promote the use and integration of mental health services into the primary care setting. Over a two year period, the program would be carried out in 25 locations.

The bill directs VA to take into consideration the needs of female veterans when establishing peer support programs, ensure that female Peer Specialists are made available to veterans through the program, and consider rural and underserved areas when selecting program locations. VA would be required to regularly report to Congress on the progress of the program including on its benefits to veterans and their family members and data on the gender of clients served by the program. Given that VA is one of the largest employers of Peer Specialists, VA's regular reporting on the program would not only allow Congress to conduct appropriate oversight of the activities, but could also provide important insights for the wider peer support community.

Given the pressing need for mental health services, it is imperative that we equip VA with the resources and organizational structure it needs to care for veterans who access these services and to find ways to reach more veterans with effective mental health services when they need them. Expanding the peer support model into the primary care setting could provide another opportunity for veterans to access mental health services through VA. As a nation we have asked more of these individuals than most of us can comprehend. We must now honor the promise we made as a nation—to take care of those who have taken care of us.

Mr. President, I ask unanimous consent that the text of the bill and letters of support be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 2210

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Veteran Partners' Efforts to Enhance Reintegration Act" or the "Veteran PEER Act".

SEC. 2. PROGRAM ON ESTABLISHMENT OF PEER SPECIALISTS IN PATIENT ALIGNED CARE TEAM SETTINGS WITHIN MEDICAL CENTERS OF DEPARTMENT OF VETERANS AFFAIRS.

(a) PROGRAM REQUIRED.—The Secretary of Veterans Affairs shall carry out a program to establish peer specialists in patient aligned care teams at medical centers of the Department of Veterans Affairs to promote the use and integration of mental health services in a primary care setting.

(b) TIMEFRAME FOR ESTABLISHMENT OF PROGRAM.—The Secretary shall carry out the program at medical centers of the Department as follows:

(1) Not later than 180 days after the date of the enactment of this Act, at not fewer than ten medical centers of the Department.

(2) Not later than two years after the date of the enactment of this Act, at not fewer than 25 medical centers of the Department.

(c) SELECTION OF LOCATIONS.—

(1) IN GENERAL.—The Secretary shall select medical centers for the program as follows:

(A) Not fewer than five shall be medical centers of the Department that are des-

ignated by the Secretary as polytrauma centers.

(B) Not fewer than ten shall be medical centers of the Department that are not designated by the Secretary as polytrauma centers.

(2) CONSIDERATIONS.—In selecting medical centers for the program under paragraph (1), the Secretary shall consider the feasibility and advisability of selecting medical centers in the following areas:

(A) Rural areas and other areas that are underserved by the Department.

(B) Areas that are not in close proximity to an active duty military installation.

(C) Areas representing different geographic locations, such as census tracts established by the Bureau of the Census.

(d) GENDER-SPECIFIC SERVICES.—In carrying out the program at each location selected under subsection (c), the Secretary shall ensure that—

(1) the needs of female veterans are specifically considered and addressed; and

(2) female peer specialists are included in the program.

(e) REPORTS.—

(1) PERIODIC REPORTS.—

(A) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, and not less frequently than once every 180 days thereafter until the Secretary determines that the program is being carried out at the last location to be selected under subsection (c), the Secretary shall submit to Congress a report on the program.

(B) ELEMENTS.—Each report required by subparagraph (A) shall include the following:

(i) The findings and conclusions of the Secretary with respect to the program during the 180-day period preceding the submittal of the report.

(ii) An assessment of the benefits of the program to veterans and family members of veterans during the 180-day period preceding the submittal of the report.

(2) FINAL REPORT.—Not later than 180 days after the Secretary determines that the program is being carried out at the last location to be selected under subsection (c), the Secretary shall submit to Congress a report detailing the recommendations of the Secretary as to the feasibility and advisability of expanding the program to additional locations.

Chicago, IL, October 14, 2015.

Hon. RICHARD BLUMENTHAL,
U.S. Senate,
Washington, DC.

DEAR SENATOR BLUMENTHAL: On behalf of the Depression and Bipolar Support Alliance (DBSA), it is with great pleasure that I endorse the Veteran Partners' Efforts to Enhance Reintegration (PEER) Act. This bill addresses a critically important gap within the U.S. Department of Veterans Affairs (VA) that inhibits access to behavioral health services. We look forward to working with you to improve veterans' access to care.

Since 2013, the VA has effectively used peer support specialists to enhance behavioral health care delivered to veterans in behavioral health settings. Yet, a majority of veterans in need of behavioral health care will enter the VA system through a primary care center. To help create the necessary connection from primary care to behavioral health services, the PEER Act will utilize behavioral health peer support specialists to assist veterans in various primary care settings.

Specifically, the bill will require the VA to establish a pilot program to assess the feasibility and advisability of establishing peer support specialists in Patient Aligned Care Teams within VA medical centers to promote the use and integration of mental health services into the primary care set-

ting. DBSA strongly supports the requirement that VA medical centers give special consideration to the needs of female veterans when designing the pilot programs and ensure that female peer support specialists are available in each of the pilot locations. We also welcome the collection and reporting of data that will be provided to Congress every six months from the pilot. The VA utilizes the largest number of peer support specialists in the nation. As such, this data will help improve the role of the peer support specialists within the VA and throughout America's entire health care system.

As the leading peer-led organization supporting individuals with mood disorders and their families, DBSA understands the importance of peer support for individuals with a behavioral health condition. We feel strongly that expanded use of peer specialists within the VA will increase veteran engagement in their care, and lead to better outcomes and sustained wellness. We applaud you for leading this new effort and stand ready to support the VA as it implements this pilot program.

Sincerely,
ALLEN DOEDERLEIN,
President,
Depression and Bipolar Support Alliance.

NATIONAL ALLIANCE ON
MENTAL ILLNESS,
Arlington, VA, October 26, 2015.

Hon. RICHARD BLUMENTHAL,
U.S. Senate,
Washington, DC.

DEAR SENATOR BLUMENTHAL: On behalf of the National Alliance on Mental Illness (NAMI), I am writing to offer our strong support for your proposed legislation, the Veteran Partners' Efforts to Enhance Reintegration (PEER) Act. As the nation's largest organization representing people living with serious mental illness and their families, NAMI is pleased to support this important legislation.

As you know, the Department of Veterans Affairs (VA) currently uses Peer Specialists to assist veterans living with mental illness. These Peer Specialists do a tremendous job in helping veterans' access mental health services and navigate the complicated VA health care system. Every day they promote recovery through development of self-management skills and assistance in moving toward employment and community integration.

Your PEER bill would direct the VA to establish a pilot program to assess the feasibility of "going to scale" in the VA with a peer support program built on Patient Aligned Care Teams within VA medical centers across the nation. This would be a major step forward in promoting integration of mental health services into primary care settings. Your bill would also direct the VA to specifically take into consideration the needs of female veterans when designing pilot programs and to ensure that female peer support specialists are available in each of the pilot locations.

NAMI strongly supports this effort to expand access to peer specialists in the VA. Thank you for bringing this important legislation forward. NAMI looks forward to working with you to ensure its swift passage.

Sincerely,
MARY GILIBERTI.

MILITARY OFFICERS ASSOCIATION
OF AMERICA
Alexandria, VA, October 26, 2015.

Hon. RICHARD BLUMENTHAL,
Ranking Member, Committee on Veterans Affairs, U.S. Senate, Washington, DC.

DEAR SENATOR BLUMENTHAL: On behalf of the more than 390,000 members of the Military Officers Association of America

(MOAA), I'm writing to thank you for sponsoring the "Veteran Partners Efforts to Enhance Reintegration (PEER) Act," a bill that would establish a two-year pilot program that requires the Department of Veterans Affairs to establish peer specialists in patient aligned care teams at 25 medical center locations.

MOAA has long supported peer support programs as a means to enhance delivery of health care services. By extending VA's existing mental health peer support model into the primary care setting helps to further reduce barriers in accessing mental health services while also supporting the Department's current efforts at integrating mental-physical health care concurrently to increase system capacity.

All veterans deserve access to mental health care when they need it and wherever they may live. As such, we are particularly grateful for special consideration in this legislation for female veterans and those living in rural or underserved areas.

I greatly appreciate your leadership and look forward to the passage of this timely legislation.

Sincerely,

NORBERT RYAN, Jr.,
President.

AMERICAN PUBLIC HEALTH ASSOCIATION,
October 23, 2015.

Hon. RICHARD BLUMENTHAL,
Ranking Member, Senate Committee on Veterans' Affairs, Washington, DC.

DEAR RANKING MEMBER BLUMENTHAL: On behalf of the American Public Health Association, a diverse community of public health professionals who champion the health of all people and communities, I write in support of the Veteran Partners' Efforts to Enhance Reintegration Act, which would require the inclusion of peer support specialists in Patient Aligned Care Teams within medical centers at the Department of Veterans Affairs.

Rates of mental illness are disproportionately high among U.S. veterans, particularly posttraumatic stress disorder, substance abuse disorders, depression, anxiety and military sexual trauma. Nearly 50 percent of combat veterans from Iraq report that they have suffered from PTSD, and close to 40 percent of these same veterans report problem alcohol use. In 2010, about 22 veterans died each day as a result of suicide. Military culture promotes inner strength, self-reliance and the ability to shake off injury, which may contribute to stigma surrounding mental health issues. Stigma may create a reluctance to seek help and a fear of negative social consequences, and is the most often cited reason for why people do not seek counseling or other mental health services.

Through a peer support model of care, Peer Specialists—veterans who have recovered or are recovering from a mental health condition—provide veterans with assistance in accessing mental health services, navigating the health care system and skills needed for a successful recovery. Expanding the peer support model to the primary care setting may offer a key entry point for those reluctant to access mental health services. The bill would also direct the VA to take into consideration the needs of female veterans and locations that are underserved.

Thank you for your commitment to the health and wellbeing of U.S. veterans and to improving access to mental health services within the VA.

Sincerely,

GEORGES C. BENJAMIN, MD,
Executive Director.

AMENDMENTS SUBMITTED AND PROPOSED

SA 2749. Mr. BURR (for himself and Mrs. FEINSTEIN) proposed an amendment to

amendment SA 2716 proposed by Mr. BURR (for himself and Mrs. FEINSTEIN) to the bill S. 754, to improve cybersecurity in the United States through enhanced sharing of information about cybersecurity threats, and for other purposes.

TEXT OF AMENDMENTS

SA 2749. Mr. BURR (for himself and Mrs. FEINSTEIN) proposed an amendment to amendment SA 2716 proposed by Mr. BURR (for himself and Mrs. FEINSTEIN) to the bill S. 754, to improve cybersecurity in the United States through enhanced sharing of information about cybersecurity threats, and for other purposes; as follows:

On page 11, line 3, strike "period" and insert "periodic".

On page 11, line 10, strike "532" and insert "632".

On page 20, line 21, strike "measures" and insert "measure".

On page 56, line 8, strike "and" and all that follows through "(7)" on line 9 and insert the following:

(7) the term "national security system" has the meaning given the term in section 11103 of title 40, United States Code; and

(8) On page 57, line 8, strike "and".

On page 57, line 11, strike the period at the end and insert "; and".

On page 57, between lines 11 and 12, insert the following:

"(4) the term 'national security system' has the meaning given the term in section 11103 of title 40, United States Code.

On page 64, lines 14 and 15, strike "Notwithstanding section 202, in this subsection" and insert "In this subsection only".

On page 69, line 13, strike "all taken" and insert "taken all".

On page 76, line 22, insert "and the Director of the Office of Management and Budget" after "Intelligence".

On page 77, lines 12 and 13, strike ", as defined in section 11103 of title 40, United States Code".

On page 77, line 14, insert "and the Director of the Office of Management and Budget" after "Intelligence".

On page 78, between lines 2 and 3, insert the following:

(d) **RULE OF CONSTRUCTION.**—Nothing in this section shall be construed to designate an information system as a national security system.

On page 78, line 18, strike "owned" and insert "used".

Beginning on page 80, line 25, strike "use" and all that follows through "other" on page 81, line 6, and insert "intrusion detection and prevention capabilities under section 230(b)(1) of the Homeland Security Act of 2002 for the purpose of ensuring the security of".

On page 84, line 25, strike "Act" and insert "Act of 2015".

On page 85, between lines 11 and 12, insert the following:

(D) the Committee on Commerce, Science, and Transportation of the Senate;

On page 86, line 26, insert "the Director of the National Institute of Standards and Technology and" after "coordination with".

On page 88, line 8, strike "non-civilian" and insert "noncivilian".

On page 89, line 23, insert ", the Director of the National Institute of Standards and Technology," after "Director".

On page 91, line 11, strike "203 and 204" and insert "303 and 304".

On page 91, line 21, insert ", in consultation with the Director of the National Institute of Standards and Technology," after "Security".

On page 92, line 9, insert ", in consultation with the Director of the National Institute

of Standards and Technology," after "Secretary".

On page 96, line 19, strike "likely," and insert "likely".

On page 96, line 22, strike "present" and insert "present".

Beginning on page 103, strike line 10 and all that follows through page 105, line 24, and insert the following:

(1) **IN GENERAL.**—Not later than 60 days after the date of enactment of this Act, the Secretary, in consultation with the Director of the National Institute of Standards and Technology and the Secretary of Homeland Security, shall convene health care industry stakeholders, cybersecurity experts, and any Federal agencies or entities the Secretary determines appropriate to establish a task force to—

(A) analyze how industries, other than the health care industry, have implemented strategies and safeguards for addressing cybersecurity threats within their respective industries;

(B) analyze challenges and barriers private entities (notwithstanding section 102(15)(B), excluding any State, tribal, or local government) in the health care industry face securing themselves against cyber attacks;

(C) review challenges that covered entities and business associates face in securing networked medical devices and other software or systems that connect to an electronic health record;

(D) provide the Secretary with information to disseminate to health care industry stakeholders for purposes of improving their preparedness for, and response to, cybersecurity threats affecting the health care industry;

(E) establish a plan for creating a single system for the Federal Government to share information on actionable intelligence regarding cybersecurity threats to the health care industry in near real time, requiring no fee to the recipients of such information, including which Federal agency or other entity may be best suited to be the central conduit to facilitate the sharing of such information; and

(F) report to Congress on the findings and recommendations of the task force regarding carrying out subparagraphs (A) through (E).

(2) **TERMINATION.**—The task force established under this subsection shall terminate on the date that is 1 year after the date of enactment of this Act.

(3) **DISSEMINATION.**—Not later than 60 days after the termination of the task force established under this subsection, the Secretary shall disseminate the information described in paragraph (1)(D) to health care industry stakeholders in accordance with such paragraph.

(4) **RULE OF CONSTRUCTION.**—Nothing in this subsection shall be construed to limit the antitrust exemption under section 104(e) or the protection from liability under section 106.

(e) **CYBERSECURITY FRAMEWORK.**—

(1) **IN GENERAL.**—The Secretary shall establish, through a collaborative process with the Secretary of Homeland Security, health care industry stakeholders, the National Institute of Standards and Technology, and any Federal agency or entity the Secretary determines appropriate, a single, voluntary, national health-specific cybersecurity framework that—

(A) establishes a common set of voluntary, consensus-based, and industry-led standards, security practices, guidelines, methodologies, procedures, and processes that serve as